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ABSTRACT

If a therapist conceptualizes human behavior systemically, he may process information and devise therapeutic strategies from many different vantage points, ranging from the intrapsychic to the macrosystemic. Although psychodiagnostic examination of the individual has a long history in the field of psychology, and psychodiagnostics can greatly facilitate treatment planning, their utility is seldom considered as an aspect of family treatment. The most frequent systemic criticism of psychological diagnosis is that it may label a patient, keeping the family system stuck on the patient rather than on the need for system changes. It has been argued, however, that at times labeling a patient within the system has beneficial effects, relieving family members of excessive guilt and unwarranted expectations. This paper presents three cases to illustrate the use of psychodiagnostic examination in a systems-oriented therapy; in each instance, the data are shared with the relevant members of the family system, there is a clear rationale for the request for evaluation, and the information gained has significant input into the therapeutic process, going beyond the mere labeling of the patient by diagnostic category and treatment recommendations. (NRB)

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THE USE OF PSYCHODIAGNOSTIC EVALUATION IN SYSTEMS THERAPY

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Paper presented at the Annual Convention of the American Psychological Association, Toronto, Canada, August 24-28, 1984.

The Use of Psychodiagnostic Evaluation in Systems Therapy

Don-David Lusterman, Ph.D.*

The place of the individual in family therapy is widely debated. Bodin (1981) reports that "I once heard Jay Haley call into question the existence not only of personality, but even of the individual." Fogarty, (1983) on the other hand, while conceptualizing the individual patient in terms of his or her place in the family system, describes himself as "willing to see one person alone, as long as he has something useful in mind," by which he means a readiness to explore self-issues in the context of family membership. Gurman (1978) cautions against establishing a "false dichotomy between individual-intrapsychic change and interactional-structural change," and argues for an integration of these positions. This paper deals in general with this integrative position, and in particular with the use of psychodiagnostic evaluation in family therapy. It explores the notion that an isomorphism exists between data derived from the study of the individual, and that derived from the larger system.

Psychodiagnostics and the System

Psychodiagnostic examination of the individual has a long and honorable history in the field of psychology. Until the late 1940's, it was probably the most well-defined skill for the practising psychologist at a time when few psychologists practised psychotherapy. In fact, the psychologists's diagnostic efforts were frequently used in the subsequent psychiatric treatment of the patient. To the present day, the teaching of psychodiagnostic skills occupies a prominent

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place in the curricula of doctoral-level programs in clinical, counseling and school psychology, usually integrated into the teaching of psychotherapy and generally taught from the point of view of individually-oriented therapy.

Psychodiagnostics, in skilled hands, can greatly facilitate treatment planning, and yet their utility appears to be seldom considered as an aspect of family treatment. A review of the major journals of family therapy over the last five years reveals not a single article devoted to this topic, although a few (Grunebaum and Chasin, 1978; Kaslow and Cooper, 1978, and Rist and Harrell, 1982) deal with this issue peripherally.

This is not to imply that family therapists may not, in fact, use psychodiagnostics as part of their armamentarium. It may be simply that it is not discussed openly, in much the same way that many family therapists, although they do see some patients alone, do not as a rule discuss this openly. This "taboo" is probably the result of a bias toward the interactional-structural approach, and away from the individual-intrapsychic orbit.

Psychologists who forget their heritage in learning theory, psychodiagnostics, and other well-learned abilities particular to psychology are analogous to psychiatrists who, having accepted a psychoanalytic position, abandon the entire medical tradition of the role of biology in understanding man, or the social worker who abandons the base of social theory inplicit in that discipline. Each profession brings a particular richness to family therapy, and this interdisciplinary quality is an important strength of the family therapy movement. By the same token, its loss is ultimately a loss for the field.

It is a misunderstanding of the ecological position to imagine that one can conceptualize the system to the exclusion of the elements and subelements that constitute it. The study of the darter snail in its position in the ecology is not mutually exclusive to the study of that organism as a biological

entity. The level of system that we study is dependent upon our viewpoint, and not on any objective reality. If we think of man as possessing body and soul, these elements can be construed as a system, as can husband and wife, parents and child, the trigenerational family, and the interaction of all of the above. For this reason, if the therapist conceptualizes human behavior from a systemic position, he or she may process information and devise therapeutic strategies from many different vantage points, ranging from the intrapsychic to the macrosystemic. An example of this movement from level to level is described by Kaslow and Cooper (1978) in reference to learning disability. They adivse a multidisciplinary evaluation, including physiological, psychological, social, familial and environmental factors. They caution that: "A most serious and possibly harmful situation is failure to formulate a correct diagnosis. If the therapist proceeds . . . not realizing the child is learning disabled, he is destined to the same disappointment as the parents and unfortunately is as likely as not to blame the parents."

Diagnosis and Labeling

The most frequent criticism of psychological diagnosis from a systems viewpoint is that it may serve to label a patient, thus risking increased scapegoating and keeping the system stuck around the issue of the identified patient, rather than on the need for change within the system. Grunebaum and Chasin (1978) remind us that traditional labeling theory usually contends that pathological labels contribute to pathology, and benign labels help alleviate it. But they point out that, at times, labeling a patient within the system may have beneficial effects. For example, they cite Montalvo and Haley (1973), who suggested that the child therapist may be effective not so much because of his mode of therapy as because he or she begins by accepting

the parental labeling of the child as "disturbed," and then, through occasional contacts with the parents, subtly undermines that idea by suggesting parental change.

Rist and Harrell (1982) in discussing the effect of labeling on learning disabled children, note that, "for the parents, the presence of a label can be an important factor in coming to better understand why their child behaves in the way that he or she does . . . and that . . . something is in need of attention and response."

Grunebaum and Chasin point out that the most frequent danger of labeling is that the label may put the labeled person in a stuck context. Thus a learning-disabled, blind or otherwise hampered child may be relegated to inferior educational contexts and may experience lowered parental and societal expectations. On the other hand, the absence of a proper label, or the therapist's message that the system <u>is</u> the problem may lead to excessive guilt on the part of patient and mate, on the one hand, or unrealistic expectations for change on the other. As an example, they include the beneficial effects of indicating to the wife of a manic depressive that her husband was physically ill, and referring the man to a psychopharmacologist. As the husband came under medical control, it was then possible to work on appropriate problems within the marriage. Diagnosis, for Grunebaum and Chasin is a name given to a pathological state. This pathology may be ascribed to the individual (e.g., this patient is suffering from anorexia nervosa) or to the system (this is a schizmatic family). Labeling, for them, is defined by the context in which the pathological label is reported to the family. They conclude that "There are many cases in which the family is told that the identified patient is potentially normal and that the family is pathogenic. Such labeling may not only be unfair

and inaccurate but also may lead to excessive expectations and guilt. In these cases, a pathological label for one member can relieve everyone, including that member, of paralyzing guilt and expectations and free the family to engage in constructive action. In general, the decision to use any label should be determined by its therapeutic impact. Sometimes labeling an individual as sick can have beneficial consequences."

Grunebaum and Chasin's discussion provides an interesting distinction between labeling and diagnosis. However, it is important to bear in mind that psychodiagnotic evaluation differs radically from the medical model of diagnosis. The medical model is essentially nomothetic, in that a name is given to a syndrome or condition. Current concepts of psychodiagnostic evaluation are idiographic, in that they are a carefully wrought description of an individual.

The purpose of psychodiagnostic evaluation is deeper than the mere provision of a label, although it may at times produce one. Woody (1969) indicates the following desiderata for psychodiagnostic evaluation: "present functioning or characteristics should be evaluated and described; possible causative factors or etiology should be posited; and a prognosis should be made and a treatment approach recommended." Dana (1980) points out the value of diagnostic information being communicated to both patient and family in a sensitive and informative manner. "From the client's standpoint, hearing about oneself . . . can be a unique event. [By communicating the findings openly] m]uch of the assessment mystique is thereby removed and replaced by a realistic and appropriate knowledge."

Rationale and Method

In some instances, interactional-structural hypotheses prove insufficient to further treatment goals, and both the identified patient and the system remain stuck. In such instances, it is responsible to explore the hypothesis that new information about the identified patient might be of value in furthering treatment. It is at this point that a psychodiagnostic workup is suggested. The diagnostician or diagnostic team should have a broad base of knowledge and skills in traditional psychological and educational evaluative techniques, in addition to a sensitivity to systemic issues.

Since the issue of an additional expenditure for the diagnostic service and indeed the willingness of the parents to cooperate in this plan may arise, time is set aside for the therapist to discuss this idea with the parents alone if the identified patient is a minor, or incapable of making the decision on his or her own.

The therapist explains that the changes in the family are not producing the desired change in the "patient," and that additional information might be of help. If the patient is a minor, it is indicated that the information will first be shared with the parents in language understandable to them, and with time to ask whatever questions they need answered. Soon after, a similar session will be arranged with the child. It is pointed out that the therapist's sharing information with the child may spur feelings or questions that he or she will wish to talk over with the parents, and if they have a prior understanding, they will be in the best position to help the child. This has the advantage of reinforcing the parents' hierarchical position in the family structure as well.

An example of the introduction of this subject follows: "Although the school appears convinced that your child could be doing better, and that family therapy

would help you as parents to help him improve, the more we work, the more I come to feel that the situation may be more complicated. Johnny seems frequently bewildered when we talk, and unable to understand what is being said. I am not sure whether this is happening because of some emotional factor, or because his intellectual ability is less than I at first believed, or perhaps because of some problem in learning. I believe that a full evaluation might help answer these questions, and provide some new ideas for all of us, myself included."

Case I

The parents of four children, ranging in age from seven years to eight months, were referred by the school because of their extremely punitive and angry reactions to their eldest sons's poor performance in school. He was frequently expelled from class, spending considerable time in the principal's office. The parents were of working-class background, but highly upwardly mobile. Both had done poorly in school, and were eager that their children would excel academically, in line with the expectations of the upper-middle class community in which they now lived. It was noted early in therapy that Mother tended to take the more angry and punitive role, and Father was protective of the boy and critical of his wife.

Even as this situation ameliorated, Billy continued to perform poorly. When the school would send home a negative report, the cycle would begin anew, even if there had been a period of relative calm. At this point, I suggested that psychodiagnostics might help us to understand better why Billy was not improving, even though his parents had become somewhat more supportive. Testing revealed a WISC Verbal IQ of 135, Performance of 114, and a Full Scale IQ of 127. The Bender did not reveal visual-motor problems, but there were emotional indicators of impulsivity, short attention span, and anxiety. Projective testing revealed signs of guilt and anxiety over his poor performance, and a

fear of consequent parental rejection.

The evaluator recommended the continuation of family therapy, but also suggested remedial therapy from a well-trained learning disability teacher, rather than the tutor they were presently using, who unwittingly joined the parents in pressuring the child for improved performance. They expressed relief when it was explained to them that the discrepancy between Billy's verbal and performance abilities led adults to expect more of him than he could deliver at this time. They were also surprised to learn that he felt guilty and anxious about his failures, since they believed that he was simply rebellious and willful. Billy was relieved to understand something of why he was having so much trouble in school and at home.

His performance did improve over the next few months, with much cooperation among the school, family, remedial therapist and the family therapist. The couple then requested and received about one year of marital therapy. The family was followed subsequently over a ten-year period. Almost all of the children at one point or another experienced some difficulty, ranging from a severe visual problem in one child to hyperactivity in another. In these situations the family was seen briefly, somewhere between two and five sessions. The family was able to reintegrate rapidly and return to a good level of functioning.

Case II

Jack was a 24-year old who was brought to the therapist's office by Joanne, his 23-year old girlfriend of six years. She was studying to be a psychiatric nurse, and was referred by her supervisor. She spoke fluent "psychologese." She appeared quite concerned about his mental well-being, and protective of him. He reported that he stayed mostly at home, partly because of a fear of losing control of his bowels, and partly because of a fear of "going off in public and having to be held down by people." Further conversation revealed a fear that he was going crazy. My impression was that he was

suffering from agoraphobia, and that his girlfriend was in some way involved in maintaining the agoraphobia. Joanne added that he was particularly bad now because she had forced him to question "where his life is going." Both concurred that they feared for his sanity, which in fact was their reason for consulting me. I suggested that a diagnostic workup be done as soon as possible.

The most salient feature of the diagnostic was that his diagnosis was "psychoneurosis, hysterical reaction with somatic features." Joanne, with her background in psychiatric nursing, was visibly relieved to hear that Jack was not psychotic, and immediately assured him of how important it was that he was neurotic, and not psychotic (this was in days of yore, when DSM - III had not yet made official the death of neurosis). Other aspects of the evaluation were shared with them, such as that he was of at least average intelligence, although he had failed to complete high school "because he didn't think he had the brains to." It was also pointed out that until he found a way of getting in touch with and expressing his feelings, he would not be able to socialize appropriately, nor would he feel physically well, since bad feelings would come out in physical symptoms such as his current stomach problems. At this point, Joanne volunteered that she should absent herself from therapy, since she was sure that there were things that Jack needed to talk over alone. Jack concurred. He was seen alone for the remaining eleven sessions, held over a period of five months with decreasing frequency.

During that time, he took an external examination leading to his high school diploma, overcame his stomach symptoms and agoraphobia, and, finally, revealed that the root of his "problem" lay in his not dealing honestly with his wish to break up with Joanne. At the final session, he was preparing to move from his parents' home, and to end his relationship with Joanne. He expressed a desire to enter a more adult relationship "with someone who sees me as a man."

Case III

Jane, 13,was the youngest of 5 children, the others ranging in age from 19 to 35, and all living out of the home. The family was referred by a school psychologist, who felt that her family situation was implicated in her very poor performance and lackadaisical attitude toward school. Her parents reported at the very first meeting that their family life was very unsatisfactory, and that only the night before they had angrily threatened to separate. Jane and her parents agreed that their attitude as parents varied from laissez-faire to angry putdowns. Both mother and father were extremely moody and frequently screamed at one another or at Jane, who followed suit. Sarcasm and silence were the other major ways of communicating. After a year of work, all three agreed that the parents were doing better in their relationship, and that Jane appeared happier than she had in the past. Nonetheless, toward the end of the first year of treatment, the mother slipped me a note on the way out of a session attached to a newspaper clipping describing the possible effects of childbirth drugs on subsequent learning disability, and wondering if Jane might not be suffering from this problem. After speaking with her, I raised the issue in a session, and all agreed that testing would be useful, although Jane predicted that the testing would show that she was not learning disabled. Testing confirmed no learning disability, but placed her intellectual functioning at the upper end of the dull average range. The diagnostician recommended a placement in an easier track, which the parents had until then adamantly resisted. He also suggested that the parents decrease their involvment in her school work, but increase their encouragement of her strong interest in art. These recommendations were carried out. Within a few months, the parents reported that Jane was happier in school and getting good reports from her teachers. She was also enrolled in an art program after school and on weekends, and loved it, all agreed. Therapy was completed within about two

months after the diagnostic workup. At last report, Jane had successfully completed high school and was enrolled in an arts college.

Discussion

The three cases presented are illustrative of the use of psychodiagnostic evaluation in systems-oriented therapy. In each instance, the data was shared with the relevant members of the system, rather than merely being treated as an advisory to the therapist. There was a clear rationale for the request for evaluation, and the information had significant input into the therapeutic process. The reports went beyond the mere labeling of the patient in terms of a diagnostic category, and treatment recommendations.

Finally, it should be noted that each family mentioned with appreciation the positive impact that the diagnostic evaluation had had on their situation.

References

Bodin, A. The interactional view: Family therapy approaches of the Mental Research Institute. In A. Gurman to D. Kniskern (Eds.), Handbook of Family Therapy, New York: Brunner/Mazel, 1981.

Dana, R. Receptivity to clinical interpretation. In R. H. Woody (Ed.) Encyclopedia of Clinical Assessment. San Francisco: Jossey-Bass Publ., 1980, pp. 1042-1049.

Fogarty, T. The art of working with individuals in family therapy. The Family, 1983, 11:1, 3-7.

Grunebaum, H. & Chasin, R. Relabeling and reframing reconsidered: The beneficial effects of a pathological label. Family Process, 1983, 17, 449-455.

Gurman, A. Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral and systems approaches. In T. Paolino, Jr. & B. McCrady (Eds.), Marriage and Marital Therapy. New York: Brunner/Mazel, 1978.

Kaslow, F. & Cooper, B. Family therapy with the learning disabled child and his/her family. Journal of Marriage and Family Counseling, 1978, 4, 41-49.

Montalvo, B. & Haley, J. In defense of child therapy. Family Process, 1973, 12, 227-244.

Rist, R. & Harrell, J. Labeling the learning disabled child: The social ecology of Educational practice. American Journal of Orthopsychiatry, 1982, 52, 146-159.

Woody, R. H. Behavioral Problem Children in the Schools: Recognition, Diagnosis and Behavioral Modification. New York: Appleton - Century-Crofts, 1969, P. 77.